Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

FONDREN ORTHOPEDIC GROUP
7401 SOUTH MAIN
HOUSTON TEXAS 77030

Respondent Name
LIBERTY INSURANCE CORP

Carrier's Austin Representative
Box Number 01

MFDR Tracking Number
M4-12-3573-01

MFDR Date Received
August 10, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary taken from the Request for Reconsideration letter: "Claim was processed and CPT code 15430 was denied stating charge was not reflected in the report as one of the procedures performed. However this is incorrect we billed 15430 for the bio-fiber augmentation and it documented. I have underlined the point of interest in the attached operative report."

Amount in Dispute: $323.19

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier did not submit a response to the DWC060 request. A copy was placed in the carrier representative box number 1 assigned to JT Parker & Associates LLC on August 17, 2012. The DWC060 packet was picked up by Jackie Winans on August 20, 2012. A decision will therefore be issued based on the documentation contained in the dispute at the time of the audit.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 2, 2011	15430	$323.19	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - X901 – Documentation does not support level of service billed.
   - X133 – This charge was not reflected in the report as one of the procedures or services performed.

Issues

1. Did the requestor bill in conflict with the NCCI edits?
2. Did the requestor document on the operative report, CPT code 15430?
3. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.203 "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."
    - The requestor seeks reimbursement for CPT code 15430 defined as "Acellular xenograft implant; first 100 sq cm or less, or 1% of body area of infants and children."
    - The requestor billed the following CPT codes on December 2, 2011; 29827-RT, 15430-RT, 29828-RT, 29826-RT, and 29822-59-RT. CCI edits were run to identify if the CPT codes billed on December 2, 2011 contain NCCI edits conflicts and no edit conflicts were identified for CPT code 15430.
    - No NCCI edit conflicts were identified for disputed CPT code 15430; therefore the disputed charges will be reviewed according to the applicable guidelines.
2. 28 Texas Administrative Code §133.307 "(c) Requests. Requests for MFDR shall be filed in the form and manner prescribed by the division. Requestors shall file two legible copies of the request with the division (2) Health Care Provider or Pharmacy Processing Agent Request. The requestor shall provide the following information and records with the request for MFDR in the form and manner prescribed by the division. The provider shall file the request with the MFDR Section by any mail service or personal delivery. The request shall include: (M) a copy of all applicable medical records related to the dates of service in dispute. . ."
    - The requestor seeks reimbursement for CPT code 15430 denied by the insurance carrier with denial reason code "X901 – Documentation does not support level of service billed" and "X133 – This charge was not reflected in the report as one of the procedures or services performed."
    - CPT code 15430 is defined by AMA CPT as "Acellular xenograft implant; first 100 sq cm or less, or 1% of body area of infants and children."
    - Review of the operative report dated December 2, 2011 states in part, "A Bio-Fiber was then shuttled down these sutures in the foot print of the repair. Sutures from this anchor were then shuttled through the most medical aspect of suraspinatus using the ExpresSew in a horizontal mattress fashion. . ."
    - The requestor's documentation does not document in the operative report that acellular xenograft implant; first 100 sq cm or less was performed/rendered, as a result, reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 13, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.